

HAWAII ADMINISTRATIVE RULES

TITLE 16

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

CHAPTER 12

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

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§16-12-1 Purposes. The purposes of this chapter are:

- (1) To provide for the reasonable standardization of coverage and simplification of terms and benefits of medicare supplement policies;
- (2) To facilitate public understanding and comparison of the policies;
- (3) To eliminate provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims; and
- (4) To provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for medicare. [Eff 5/17/82; comp 10/28/89; comp 12/27/90; am and comp 9/3/92; comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-305, 431:10A-306, 431:10A-309)

§16-12-2 Applicability and scope. (a) Except as otherwise specifically provided, this chapter shall apply to:

- (1) All medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this chapter; and
- (2) All certificates issued under group medicare supplement policies which certificates have been delivered or issued for delivery in this State.

(b) This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations. [Eff 5/17/82; am and comp 10/28/89; comp 12/27/90; am and comp 9/3/92; comp 7/6/99; comp 10/15/01;

comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-302, 431:10A-305)

§16-12-2.3 Laws applicable. Article 10A, part I, of chapter 431, HRS, governing individual accident and sickness policies shall apply to medicare supplement policies unless expressly inconsistent with article 10A, part III, of chapter 431, HRS, and this chapter, in which case part III and this chapter shall prevail. [Eff and comp 10/28/89; comp 12/27/90; am and comp 9/3/92; comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-304, 431:10A-305)

§16-12-3 Definitions. Unless the context indicates otherwise, as used in this chapter:

"Applicant" means:

- (1) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and
- (2) In the case of a group medicare supplement policy, the proposed certificateholder.

"Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

"Certificate" means any certificate delivered or issued for delivery in this State under a group medicare supplement policy.

"Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three days.

"Creditable coverage":

- (1) Means, with respect to an individual, coverage of the individual provided under any of the following:
 - (A) A group health plan;
 - (B) Health insurance coverage;
 - (C) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (D) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

- (E) Chapter 55 of Title 10 United States Code (CHAMPUS);
 - (F) A medical care program of the Indian Health Service or of a tribal organization;
 - (G) A State health benefits risk pool;
 - (H) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
 - (I) A public health plan as defined in federal regulation; and
 - (J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
- (2) Shall not include one or more, or any combination of, the following:
- (A) Coverage only for accident or disability income insurance, or any combination thereof;
 - (B) Coverage issued as a supplement to liability insurance;
 - (C) Liability insurance, including general liability insurance and automobile liability insurance;
 - (D) Workers' compensation or similar insurance;
 - (E) Automobile medical payment insurance;
 - (F) Credit-only insurance;
 - (G) Coverage for on-site medical clinics; and
 - (H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) Shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
- (A) Limited scope dental or vision benefits;
 - (B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
 - (C) Such other similar, limited benefits as are specified in federal regulations.
- (4) Shall not include the following benefits if offered as independent, noncoordinated benefits:
- (A) Coverage only for a specified disease or illness; and
 - (B) Hospital indemnity or other fixed indemnity insurance.
- (5) Shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:

- (A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
- (B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
- (C) Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

"Insolvency" means when an issuer, licensed to transact the business of insurance in this State, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this State medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

- (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
- (2) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
- (3) Medicare+Choice private fee-for-service plans.

"Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations, or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395 ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

"Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Secretary" means the Secretary of the United States Department of Health and Human Services. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-301, 431:10A-305)

§16-12-4 Policy definitions and terms. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this State as a medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(b) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words as "external, violent, visible wounds," or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(c) "Benefit period" or "medicare benefit period" shall not be defined more restrictively than as defined in the medicare program.

(d) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the medicare program.

(e) "Health care expenses" mean expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. The expenses shall not include:

- (1) Home office and overhead costs;
- (2) Advertising costs;
- (3) Commissions and other acquisition costs;
- (4) Taxes;
- (5) Capital costs;
- (6) Administrative costs; and
- (7) Claims processing costs.

(f) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the medicare program.

(g) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(h) "Medicare eligible expenses" shall mean expenses of the kinds covered by medicare, to the extent recognized as reasonable and medically necessary by medicare.

(i) "Physician" shall not be defined more restrictively than as defined in the medicare program.

(j) "Sickness" shall not be defined to be more restrictive than the following:

- (1) "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."
- (2) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law. [Eff 5/17/82; am and comp 10/28/89; comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-304, 431:10A-305)

§16-12-5 Policy provisions. (a) Except for permitted preexisting condition clauses as described in section 16-12-5.4(b)(1) and section 16-12-5.5(b)(1) of this chapter, no policy or certificate may be advertised, solicited or issued for delivery in this State as a medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

(b) No medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) No medicare supplement policy or certificate in force in this State shall contain benefits which duplicate benefits provided by medicare. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-304, 431:10A-305)

§16-12-5.3 Repealed.

§16-12-5.4 Minimum benefit standards for policies or certificates issued for delivery prior to September 3, 1992. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this State as a medicare supplement policy or certificate unless it meets or exceeds the minimum standards set forth in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this chapter:

- (1) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;
- (2) A medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;
- (3) A medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage

- factors. Premiums may be modified to correspond with the changes;
- (4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" medicare supplement policy shall not:
 - (A) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
 - (B) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health;
 - (5) (A) Except as authorized by the commissioner of this State, an issuer shall neither cancel nor nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation;
 - (B) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph (D), the issuer shall offer each certificateholder an individual medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:
 - (i) An individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and
 - (ii) An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in section 16-12-6(c) of this chapter;
 - (C) If membership in a group is terminated, the issuer shall:
 - (i) Offer the certificateholder the conversion opportunities as are described in subparagraph (B); or
 - (ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy;
 - (D) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group

policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

- (6) Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.
- (c) Minimum benefit standards.
- (1) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;
- (2) Coverage for either all or none of the medicare Part A inpatient hospital deductible amount;
- (3) Coverage of Part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days;
- (4) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety per cent of all medicare Part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days;
- (5) Coverage under medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;
- (6) Coverage for the co-insurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare Part B deductible (\$100); and
- (7) Effective January 1, 1990, coverage under medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal

regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the medicare deductible amount. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am, ren §16-12-6 and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; am and comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §431:10A-305)

§16-12-5.5 Benefit standards for policies or certificates issued or delivered on or after September 3, 1992. (a) The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this State on or after September 3, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this State as a medicare supplement policy or certificate unless it complies with these benefit standards.

(b) The following are general standards that apply to medicare supplement policies and certificates and are in addition to all other requirements of this chapter:

- (1) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
- (2) A medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- (3) A medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.
- (4) No medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

- (5) Each medicare supplement policy shall be guaranteed renewable and:
 - (A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;
 - (B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;
 - (C) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (E), the issuer shall offer certificateholders an individual medicare supplement policy which (at the option of the certificateholder):
 - (i) Provides for continuation of the benefits contained in the group policy; or
 - (ii) Provides for the benefits that otherwise meet the requirements of this subsection;
 - (D) If an individual is a certificateholder in a group medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - (i) Offer the certificateholder the conversion opportunity described in subparagraph (C); or
 - (ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy; and
 - (E) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (6) Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

- (7) (A) A medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to such assistance.
- (B) If the suspension occurs and if the policyholder or certificateholder loses entitlement to the medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.
- (C) Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement in the group health plan.
- (D) Reinstitution of the coverages as provided in subparagraphs (B) and (C):
 - (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

- (ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of the suspension; and
- (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(c) The following are standards for basic ("core") benefits common to all benefit plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof.

- (1) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;
- (2) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;
- (3) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days;
- (4) Coverage under medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and
- (5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible.

(d) The following are standards for additional benefits. The following additional benefits shall be included in medicare supplement benefit plans "B" through "J" only as provided by section 16-12-6.

- (1) Medicare Part A deductible: coverage for all of the medicare Part A inpatient hospital deductible amount per benefit period;
- (2) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A;
- (3) Medicare Part B deductible: coverage for all of the medicare Part B deductible amount per calendar year regardless of hospital confinement;
- (4) Eighty per cent of the medicare Part B excess charges: coverage for eighty per cent of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge;
- (5) One hundred per cent of the medicare Part B excess charges: coverage for all of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge;
- (6) Basic outpatient prescription drug benefit: coverage for fifty per cent of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by medicare;
- (7) Extended outpatient prescription drug benefit: coverage for fifty per cent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by medicare;
- (8) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for eighty per cent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit,

"emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset;

- (9) Preventive medical care benefit: coverage for the following preventive health services:
 - (A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures;
 - (B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
 - (i) Digital rectal examination;
 - (ii) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;
 - (iii) Pure tone (air only) hearing screening test, administered or ordered by a physician;
 - (iv) Serum cholesterol screening (every five years);
 - (v) Thyroid function test; and
 - (vi) Diabetes screening;
 - (C) Tetanus and diphtheria booster (every ten years); and
 - (D) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred per cent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMACPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

- (10) The following are at-home recovery benefits: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.
 - (A) For purposes of this benefit, the following definitions shall apply:
 - "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

"Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

"Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

"At-home recovery" visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

- (B) The following are coverage requirements and limitations:
- At-home recovery services provided must be primarily services which assist in activities of daily living. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare. Coverage is limited to:
- (i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of medicare-approved home health care visits under a medicare-approved home care plan of treatment;
 - (ii) The actual charges for each visit up to a maximum reimbursement of \$40 per visit;
 - (iii) \$1,600 per calendar year;
 - (iv) Seven visits in any one week;
 - (v) Care furnished on a visiting basis in the insured's home;
 - (vi) Services provided by a care provider as defined in this section;

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- (vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and
 - (viii) At-home recovery visits received during the period the insured is receiving medicare-approved home care services or no more than eight weeks after the service date of the last medicare-approved home health care visit.
- (C) Coverage is excluded for:
 - (i) Home care visits paid for by medicare or other government programs; and
 - (ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.
- (11) New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. [Eff and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; am and comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-306, 431:10A-307, 431:10A-309, 431:10A-310) (Imp: HRS §§431:10A-304, 431:10A-305)

§16-12-6 Standard medicare supplement benefit plans. (a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in subsection 16-12-5.5(c).

(b) No groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall be offered for sale in this State, except as may be permitted in paragraph 16-12-5.5(d)(11) and section 16-12-6.1.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in subsection (e) and conform to the definitions in section 16-12-3. Each benefit shall be structured in accordance with the format provided in subsections (c) and (d) of section

16-12-5.5 and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subsection (c), other designations to the extent permitted by law.

(e) The composition of the benefit plans is as follows:

- (1) Standardized medicare supplement benefit plan "A" shall be limited to the basic ("core") benefits common to all benefit plans, as defined in subsection 16-12-5.5(c);
- (2) Standardized medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible as defined in paragraph 16-12-5.5(d)(1);
- (3) Standardized medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible and medically necessary emergency care in a foreign country as defined in paragraphs 16-12-5.5(d)(1), (2), (3), and (8) respectively;
- (4) Standardized medicare supplement benefit plan "D" shall include only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in paragraphs 16-12-5.5(d)(1), (2), (8), and (10) respectively;
- (5) Standardized medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in paragraphs 16-12-5.5(d)(1), (2), (8), and (9) respectively;
- (6) Standardized medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred per cent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 16-12-5.5(d)(1), (2), (3), (5), and (8) respectively;

- (7) Standardized medicare supplement benefit high deductible plan "F" shall include only the following: One hundred per cent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection 16-12-5.5(c) of this regulation, plus the medicare Part A deductible, skilled nursing facility care, the medicare Part B deductible, one hundred per cent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 16-12-5.5(d)(1), (2), (3), (5), and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be \$1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10;
- (8) Standardized medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, eighty per cent of the medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs 16-12-5.5(d)(1), (2), (4), (8), and (10) respectively;
- (9) Standardized medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in paragraphs 16-12-5.5(d)(1), (2), (6), and (8) respectively;
- (10) Standardized medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, one hundred per cent of the medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit

as defined in paragraphs 16-12-5.5(d)(1), (2), (5), (6), (8), and (10) respectively;

- (11) Standardized medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection 16-12-5.5(c), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, one hundred per cent of the medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in paragraphs 16-12-5.5(d)(1), (2), (3), (5), (7), (8), (9), and (10) respectively; and
- (12) Standardized medicare supplement benefit high deductible plan "J" shall consist of only the following: One hundred per cent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection 16-12-5.5(c) of this regulation, plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, one hundred per cent of the medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in paragraphs 16-12-5.5(d)(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. [Eff and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-307, 431:10A-309, 431:10A-310) (Imp: HRS §§431:10A-304, 431:10A-305, 431:10A-307, 431:10A-309, 431:10A-310)

§16-12-6.1

§16-12-6.1 Medicare select policies and certificates. (a)(1) This section shall apply to medicare select policies and certificates, as defined in this section;

(2) No policy or certificate may be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

"Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

"Grievance" means dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select issuer or its network providers.

"Medicare select issuer" means an issuer offering, or seeking to offer, a medicare select policy or certificate.

"Medicare select policy" or "medicare select certificate" mean respectively a medicare supplement policy or certificate that contains restricted network provisions.

"Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy.

"Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

"Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a medicare select policy.

(c) The commissioner may authorize an issuer to offer a medicare select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(d) A medicare select issuer shall not issue a medicare select policy or certificate in this State until its plan of operation has been approved by the commissioner.

(e) A medicare select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(A) The services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of

- operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
- (B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:
 - (i) To deliver adequately all services that are subject to a restricted network provision; or
 - (ii) To make appropriate referrals.
 - (C) There are written agreements with network providers describing specific responsibilities.
 - (D) Emergency care is available twenty-four hours per day and seven days per week.
 - (E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate.
- (2) A statement or map providing a clear description of the service area;
 - (3) A description of the grievance procedure to be utilized;
 - (4) A description of the quality assurance program, including:
 - (A) The formal organizational structure;
 - (B) The written criteria for selection, retention and removal of network providers; and
 - (C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
 - (5) A list and description, by specialty, of the network providers.
 - (6) Copies of the written information proposed to be used by the issuer to comply with subsection (i) of this section; and
 - (7) Any other information requested by the commissioner.
 - (f)(1) A medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. The

changes shall be considered approved by the commissioner after thirty days unless specifically disapproved.

- (2) An updated list of network providers shall be filed with the commissioner at least quarterly.
- (g) A medicare select policy or certificate shall not restrict payment for covered services provided by non-network providers if:
 - (1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
 - (2) It is not reasonable to obtain the services through a network provider.
- (h) A medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
 - (i) A medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure shall include at least the following:
 - (1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with:
 - (A) Other medicare supplement policies or certificates offered by the issuer; and
 - (B) Other medicare select policies or certificates.
 - (2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.
 - (3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.
 - (4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
 - (5) A description of limitations on referrals to restricted network providers and to other providers.
 - (6) A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.
 - (7) A description of the medicare select issuer's quality assurance program and grievance procedure.

(j) Prior to the sale of a medicare select policy or certificate, a medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (i) of this section and that the applicant understands the restrictions of the medicare select policy or certificate.

(k) A medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

- (1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage;
- (2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer;
- (3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action;
- (4) If a grievance is found to be valid, corrective action shall be taken promptly;
- (5) All concerned parties shall be notified about the results of a grievance; and
- (6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of the grievances.

(l) At the time of initial purchase, a medicare select issuer shall make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the issuer.

- (m)(1) At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer shall make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the medicare select policy or certificate has been in force for six months.

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- (2) For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(n) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

- (1) Each medicare select issuer shall make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

- (2) For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(o) A medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the medicare select program. [Eff and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §431:10A-305)

§16-12-6.2 Open enrollment. (a) No issuer shall deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of a policy or certificate

because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is enrolled for benefits under medicare Part B. Each medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age.

- (b)(1) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.
- (2) If the applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

(c) Except as provided for in subsection (b) and in section 16-12-12.8, subsection (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before the coverage became effective. [Eff and comp 9/3/92; am, ren §16-12-6.2 and comp 7/6/99; comp 10/15/01; am and comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-304, 431:10A-305)

§16-12-6.3 Guaranteed issue for eligible persons. (a) Guaranteed issue.

- (1) Eligible persons are those individuals described in subsection (b) who, seek to enroll under the policy during the period specified in subsection (c), and who submit evidence of the date of termination or disenrollment with the application for a medicare supplement policy.
- (2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsection (e) that is offered and is available for

issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

(b) Eligible persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

(A) The certification of the organization or plan under this part has been terminated; or

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's

- contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
 - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 - (E) The individual meets such other exceptional conditions as the Secretary may provide.
 - (3) (A) The individual is enrolled with:
 - (i) An eligible organization under a contract under Section 1876 of the Social Security Act (medicare cost);
 - (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
 - (iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
 - (iv) An organization under a medicare select policy; and
 - (B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 16-12-6.3(b)(2).
- (4) The individual is enrolled under a medicare supplement policy and the enrollment ceases because:
 - (A)
 - (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or
 - (ii) Of other involuntary termination of coverage or enrollment under the policy;
 - (B) The issuer of the policy substantially violated a material provision of the policy; or
 - (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
- (5) (A) The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls,

- for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Part C of medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a medicare select policy; and
- (B) The subsequent enrollment under subparagraph (A) is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or
 - (6) The individual, upon first becoming enrolled in medicare Part B for benefits at age sixty-five or older, enrolls in a Medicare+Choice plan under Part C of medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.
 - (c) Guaranteed issue time periods.
 - (1) In the case of an individual described in subsection (b)(1), the guaranteed issue period begins on the later of:
 - (A) The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or
 - (B) The date that the applicable coverage terminates or ceases;
 and ends sixty-three days thereafter.
 - (2) In the case of an individual described in subsections (b)(2), (b)(3), (b)(5), or (b)(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;
 - (3) In the case of an individual described in subsection (b)(4)(A), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of

- termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;
- (4) In the case of an individual described in subsections (b)(2), (b)(4)(B), (b)(4)(C), (b)(5), or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the date that is sixty-three days after the effective date; and
 - (5) In the case of an individual described in subsection (b) but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.
- (d) Extended medigap access from interrupted trial periods.
- (1) In the case of an individual described in subsection (b)(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subsection (b)(5)(A) is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section (b)(5);
 - (2) In the case of an individual described in subsection (b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in subsection (b)(6) is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in section (b)(6); and
 - (3) For purposes of subsections (b)(5) and (b)(6), no enrollment of an individual with an organization or provider described in subsection (b)(5)(A); or with a plan or in a program described in subsection (b)(6), may be deemed to be an initial enrollment under this paragraph after the two-year

period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) Products to which eligible persons are entitled. The medicare supplement policy to which eligible persons are entitled under:

- (1) Paragraphs 16-12-6.3(b)(1), (2), (3), and (4), is a medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer;
- (2) Paragraph 16-12-6.3(b)(5) is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subsection (c)(1); and
- (3) Paragraph 16-12-6.3(b)(6) shall include any medicare supplement policy offered by any issuer.

(f) Notification provisions.

- (1) At the time of an event described in subsection (b) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under subsection (a). Such notice shall be communicated contemporaneously with the notification of termination.
- (2) At the time of an event described in subsection (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of medicare supplement policies under subsection 16-12-6.3(a). The notice shall be communicated within ten working days of the issuer receiving notification of disenrollment. [Eff and comp 7/6/99; am and comp 10/15/01; am and comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §431:10A-305)

§16-12-6.4 Standards for claims payment. (a) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

- (1) Accepting a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
- (2) Notifying the participating physician or supplier and the beneficiary of the payment determination;
- (3) Paying the participating physician or supplier directly;
- (4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a medicare carrier may be sent;
- (5) Paying user fees for claim notices that are transmitted electronically or otherwise; and
- (6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

(b) Compliance with the requirements set forth in subsection (a) shall be certified on the medicare supplement insurance experience reporting form. [Eff and comp 10/28/89; comp 12/27/90; am and comp 9/3/92; am, ren §16-12-6.4 and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305) (Imp: HRS §431:10A-305)

§16-12-7 Loss ratio standards and refund or credit of premium. (a) The following provisions of this subsection establish loss ratio standards:

- (1) (A) A medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

- (i) At least seventy-five per cent of the aggregate amount of premiums earned in the case of group policies; or
 - (ii) At least sixty-five per cent of the aggregate amount of premiums earned in the case of individual policies;
 - (B) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices.
- (2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.
- (3) For purposes of applying subparagraph (a)(1)(A) of this section and paragraph (c)(3) of section 16-12-7.3 only, group policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be group policies.
- (4) For policies issued prior to September 3, 1992, expected claims in relation to premiums shall meet:
 - (A) The originally filed anticipated loss ratio when combined with the actual experience since inception;
 - (B) The appropriate loss ratio requirement from clauses (a)(1)(A)(i) and (ii) when combined with actual experience beginning with the effective date of this section; and
 - (C) The appropriate loss ratio requirement from clauses (a)(1)(A)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.
- (b) The following provisions of this subsection apply to refund or credit calculations:
 - (1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A, located at the end of this chapter, which

is made a part of this section, for each type in a standard medicare supplement benefit plan.

- (2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.
- (3) For the purposes of this section, policies or certificates issued prior to September 3, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the effective date of this section. The first report shall be due by May 31, 1999.
- (4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) Annual filing of rates. An issuer of medicare supplement policies and certificates issued before or after the effective date of this chapter in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years. As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare

supplement policies or certificates in this State shall file with the commissioner, in accordance with the applicable filing procedures of this State:

- (1)
 - (A) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.
 - (B) An issuer shall make the premium adjustments as are necessary to produce an expected loss ratio under the policy or certificate as will conform with minimum loss ratio standards for medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.
 - (C) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.
 - (2) Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with medicare. The riders, endorsements, or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or certificate.
 - (3) An issuer shall file a certification signed by a qualified actuary stating that premium rates meet the minimum benefit and loss ratio standards required in article 10A of chapter 431, HRS, and this chapter. In determining the accuracy of any certification, the commissioner may require the issuer to submit any additional information.
 - (d) Public hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this chapter if the experience of the form for the previous reporting period is not

in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner as provided by law. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-306) (Imp: HRS §§431:10A-305, 431:10A-306)

§16-12-7.3 Filing and approval of policies and certificates and premium rates. (a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(b) An issuer shall not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

- (c)(1) Except as provided in paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.
- (2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:
 - (A) The inclusion of new or innovative benefits;
 - (B) The addition of either direct response or agent marketing methods;
 - (C) The addition of either guaranteed issue or underwritten coverage;
 - (D) The offering of coverage to individuals eligible for medicare by reason of disability.
- (3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.
- (d)(1) Except as provided in subparagraph (A), an issuer shall continue to make available for purchase any policy form or certificate form

issued after the effective date of this section that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

- (A) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this State.
 - (B) An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph (A) shall not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.
- (2) The sale or other transfer of medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.
 - (3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:
 - (A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
 - (B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.
- (e)(1) Except as provided in paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard medicare

supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 16-12-7.

- (2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

- (f) An issuer shall file a certification signed by an officer of the issuer stating that the contract, policy, or certificate meets the minimum benefit standards required in article 10A of chapter 431, HRS, and this chapter. In determining the accuracy of any certification, the commissioner may require the issuer to submit any additional information. [Eff and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305, 431:10A-309) (Imp: HRS §§431:10A-305, 431:10A-309)

§16-12-7.5 Repealed.

§16-12-7.6 Permitted compensation arrangements. (a) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred per cent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

(c) No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(d) For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders fees. [Eff and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305) (Imp: HRS §431:10A-305)

§16-12-8 Required disclosure provisions. (a) General rules are as follows. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, or certificate and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(d) If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(f)(1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National

Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than twelve point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

- (2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-305, 431:10A-307, 431:10A-308)

§16-12-8.3 Notice requirements. (a) As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

- (1) Include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement policy or certificate; and
 - (2) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in medicare.
- (b) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.
- (c) The notices shall not contain or be accompanied by any solicitation. [Eff and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-305, 431:10A-307, 431:10A-308)

§16-12-9 Outline of coverage requirements for medicare supplement policies. (a) Issuers shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant.

(b) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(c) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(d) The outline of coverage provided to the applicant pursuant to subsections (a), (b), and (c) shall be in the form prescribed in Exhibit A, located at the end of this chapter, which is made a part of this section. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-305, 431:10A-307, 431:10A-308)

§16-12-10 Notice regarding policies or certificates which are not medicare supplement policies. (a) Any accident and sickness insurance policy or certificate, other than a medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy, or other policy identified in subsection 16-12-2(b) of this chapter, issued for delivery in this State to persons eligible for medicare

shall notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(b) Applications provided to persons eligible for medicare for the health insurance policies or certificates described in subsection 16-12-10(a) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-305, 431:10A-307, 431:10A-308)

§16-12-11 Requirements for application forms and replacement coverage.

(a) Application forms shall include questions designed to elicit information as to whether, as of the date of the application, the applicant has another medicare supplement or other health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent may be used containing the questions and statements in substantially the form entitled Exhibit C, located at the end of this chapter, which is made a part of this section.

(b) Agents shall list any other health insurance policies they have sold to the applicant. Agents shall:

- (1) List policies sold which are still in force; and
- (2) List policies sold in the past five years which are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

(e) The notice required by subsection (d) for an issuer, shall be provided in no less than twelve point type, in substantially the form entitled as Exhibit B, located at the end of this chapter, which is made a part of this section.

(f) Paragraphs one and two of the replacement notice (applicable to preexisting conditions) in Exhibit B may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. [Eff 5/17/82; am and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; am and comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-305, 431:10A-307)

§16-12-12 Filing requirements for advertising. (a) An issuer shall provide a copy of any medicare supplement advertisement intended for use in this State whether through written, radio, or television medium to the commissioner for review or approval by the commissioner to the extent it may be required under state law. Such advertisement shall comply with all applicable laws of this State.

(b) An issuer shall file a certification signed by an officer of the issuer stating that the advertisements filed pursuant to this subsection are in accordance with the standards established by article 10A of chapter 431, HRS, and section 431:13-103, HRS. In determining the accuracy of any certification, the commissioner may require the issuer to submit any additional information. [Eff and comp 10/28/89; am and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305, 431:10A-309) (Imp: HRS §§431:10A-305, 431:10A-310, 431:13-103)

§16-12-12.2 Standards for marketing. (a) An issuer, directly or through its producers, shall:

- (1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
 - (2) Establish marketing procedures to assure excessive insurance is not sold or issued.
 - (3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:
"NOTICE TO BUYER: This policy may not cover all of your medical expenses."
 - (4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
 - (5) Establish auditable procedures for verifying compliance with this subsection.
- (b) In addition to the practices prohibited in article 13 of chapter 431, HRS, the following acts and practices are prohibited:
- (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, or to take out a policy of insurance with another issuer;
 - (2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and
 - (3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
- (c) The terms "medicare supplement," "medigap," "medicare wrap-around" and words of similar import shall not be used unless the policy is issued in compliance with this chapter. [Eff and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-305, 431:10A-307, 431:13-103)

§16-12-12.4

§16-12-12.4 Appropriateness of recommended purchase and excessive insurance. (a) In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of medicare supplement coverage that will provide an individual more than one medicare supplement policy or certificate is prohibited. [Eff and comp 12/27/90; am and comp 9/3/92; comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-305, 431:10A-307)

§16-12-12.6 Reporting of multiple policies. (a) On or before March 1 of each year, an issuer shall report to the commissioner in substantially the form entitled Appendix B, located at the end of this chapter, which is made a part of this section, the following information for every individual resident of this State for which the issuer has in force more than one medicare supplement policy or certificate:

- (1) Policy and certificate number; and
- (2) Date of issuance.

(b) The items set forth in subsection (a) must be grouped by individual policyholder. [Eff and comp 12/27/90; am and comp 9/3/92; am and comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-305, 431:10A-307, 431:10A-309) (Imp: HRS §§431:10A-305, 431:10A-307, 431:10A-309)

§16-12-12.8 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates.

(a) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

(b) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy or certificate shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. [Eff and comp 12/27/90; am and comp 9/3/92; comp 7/6/99;

comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305, 431:10A-307) (Imp: HRS §§431:10A-304, 431:10A-305, 431:10A-307)

§16-12-13 Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby. [Eff and comp 10/28/89; comp 12/27/90; comp 9/3/92; comp 7/6/99; comp 10/15/01; comp 12/9/02] (Auth: HRS §§431:2-201, 431:10A-304, 431:10A-305) (Imp: HRS §§431:10A-305, 431:10A-312)

Amendments to and compilation of chapter 16-12, Hawaii Administrative Rules, on the Summary page dated November 21, 2002, were adopted on November 21, 2002, following a public hearing held on the same date, after public notices were given in the Garden Island on October 16, 2002, The Honolulu Star Bulletin, Hawaii Tribune-Herald, West Hawaii Today, and The Maui News on October 18, 2002.

These rules shall take effect ten days after filing with the Office of the Lieutenant Governor.

/s/ Wayne C. Metcalf, III
WAYNE C. METCALF, III
Insurance Commissioner

APPROVED AS TO FORM: Date: 11/25/02

/s/ James F. Nagle
Deputy Attorney General

APPROVED: Date: _____

/s/ Kathryn S. Matayoshi
KATHRYN S. MATAYOSHI, Director
Commerce and Consumer Affairs

APPROVED: Date: 11/27/02

/s/ Benjamin J. Cayetano
BENJAMIN J. CAYETANO
Governor
State of Hawaii

Filed

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

Amendment and Compilation of Chapter 16-12
Hawaii Administrative Rules

November 21, 2002

SUMMARY

1. §16-12-5.4 is amended.
2. §16-12-5.5 is amended.
3. §16-12-6.2 is amended.
4. §16-12-6.3 is amended.
5. Chapter 12 is compiled.

This material can be made available for individuals with special needs in braille, large print or audio tape.
Please submit your request to the Insurance Division at (808) 586-2790.

Effective 12/9/02